U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 14 June 2006

In the Matter of:

TOMMY RAY HITE,
Claimant

Case No. 2004-BLA-6211

v.

KNOTT FLOYD LAND COMPANY, INC.,
Employer

and

AMERICAN INTL SOUTH,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Monica Rice Smith, Esq.
Hyden, Kentucky
For Claimant

Timothy J. Walker, Esq.
Lexington, Kentucky
For Employer/Carrier

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. §

902(b); 20 CFR § 718.201 (2005). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on December 6, 2005, in Pikeville, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). At the hearing, the Claimant was the only witness. Transcript ("Tr.") 9-22. Director's Exhibits ("DX") 1-28 and Claimant's Exhibit ("CX") 1 were admitted into evidence without objection. Tr. 6-8. The record was held open after the hearing to allow the parties to submit closing arguments. The Claimant and the Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his claim on March 19, 2003. DX 2. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on January 16, 2004. The claim was referred to the Office of Administrative Law Judges for hearing on April 28, 2004. DX 25.

APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2005). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2005).

ISSUES

The issues contested by the Employer and the Director are:

1. How long the Claimant worked as a miner.

2. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

4. Whether he is totally disabled.

5. Whether his disability is due to pneumoconiosis.

DX 25; Tr. 5. The Employer also reserved its right to challenge the statute and regulations. DX-18.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

At the hearing, Claimant testified that he is married, and his wife is dependent on him for support. Tr. 10. Claimant stated that he worked 28 years in the coal mines[1] and that he last worked for Knot Floyd Land. Tr. 11. The last position was as a superintendent. He was required to stand in the coal pit to guide the end loader. He also had to drive a water truck to keep the dust down. Tr. 11. He would have to fill in if one of his team was out. Claimant supervised around 20 men. Tr. 12. He last worked in the coal mines on February 28, 2000. Tr. 12. He stopped working due to a heart condition. Tr. 13. Most of Claimant's coal mine employment was in strip mining. Tr. 14. His last coal mine employment was in Kentucky. DX 6. Therefore this claim is governed by the law of the 6th Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

The Claimant has congestive heart failure, diabetes, arthritis, gout, and high blood pressure. Tr. 15-16. Claimant stated that he has trouble breathing at night and had dry cough. Tr. 17. He is not on any medication for his breathing. Tr. 17. He said he becomes short of breath on exertion, and weather conditions also affect his breathing. Tr. 18. Claimant stated that he smoked 10-12 cigarettes per day for five years, and that he quit 20 years ago. Tr. 19.

On cross-examination, Claimant stated that when gout flares up in his feet it interferes with his walking. He is 5'11" tall and weighed 260 pounds at the time of the hearing. Tr. 22.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2005). An x-ray interpretation which made no reference to pneumoconiosis, positive or negative, given in connection with review of an x-ray film solely to determine its quality, is listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations. Qualifications of

[1] The Director found and the Employer stipulated to 27 years of coal mine employment. Tr. 5. I find that the Claimant had at least 27 years of coal mine employment.

physicians are abbreviated as follows: B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
04/28/03	DX 8 Baker B 1/0	DX 10 Wiot B, BCR	DX 9 Barrett B, BCR Read for quality only Film quality 1

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. Bronchodilators were not administered in either study. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	Age Height[2]	FEV_1	FVC	FEV_1/ FVC	MVV	Qualify?	Physician Impression
DX 8 04/28/03 Baker	54 71.75"	2.76	3.80	73%		No	Mild obstructive defect
DX 11 09/25/03 Kahwash	54 71"	2.97	3.95	75%		No	

[2] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 71" to 71.75", I have taken the mid-point (71.375") in determining whether the studies qualify to show disability under the regulations. Neither of the tests is qualifying to show disability whether considering the mid-point, or the heights listed by the persons who administered the testing.

Arterial Blood Gas Study

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the results of the only arterial blood gas study available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2005). No exercise test was administered in this case due to the Claimant's congestive heart failure.

Exhibit Number	Date	Physician	PCO_2	PO_2	Qualify?	Physician Impression
DX 8	04/28/03	Baker	42	80	No	Normal

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2005). The record contains two reports submitted by the physician who examined the Claimant on behalf of the Department of Labor, but no other medical opinions.

Dr. Baker's first report is dated April 28, 2003 and appears at DX 8. Dr. Baker is Board-Certified in Internal Medicine and Pulmonary Disease and is a B-reader of chest x-rays. CX 1. He reviewed Claimant's occupational history noting Claimant's last coal mine job was as a foreman. Claimant had a family history of heart disease, diabetes, asthma, and emphysema.

Claimant had a medical history of pneumonia, attacks of wheezing, arthritis, heart disease, diabetes and high blood pressure. Claimant reported a smoking history of ½ pack of cigarettes per day from 1970 to 1973-74. Claimant's chief complaints included cough with sputum, wheezing, dyspnea, and ankle edema. Physical examination revealed decreased breath sounds on auscultation. Dr. Baker read the chest x-ray as positive for pneumoconiosis, 1/0. Pulmonary function tests showed a mild obstructive defect. Arterial blood gases were within normal limits, and an EKG showed normal sinus rhythm with ST-T changes in lateral leads. Dr. Baker diagnosed Claimant as having coal worker's pneumoconiosis ("CWP") based on the abnormal chest x-ray and coal dust exposure, chronic obstructive pulmonary disease with a mild obstructive impairment due to coal dust exposure/cigarette smoking based on pulmonary function studies, bronchitis due to coal dust exposure based on history of cough, sputum production, and wheezing, and congestive heart failure by history. Dr. Baker concluded that Claimant had a mild impairment with decreased FEV_1, bronchitis, and CWP.

The supplemental report of Dr. Baker is dated April 30, 2005 and appears at DX 28. He reviewed his examination report and concluded Claimant had clinical pneumoconiosis based on x-ray changes consistent with a diagnosis of CWP. Moreover, he concluded Claimant had legal pneumoconiosis since Claimant had a mild obstructive defect and mild bronchitis. He noted that both cigarette smoking and coal dust could cause this condition but that it was felt that at least a 15-pack year smoking history was required to associate it with any pulmonary symptoms. He stated that Claimant only had a 2-pack year smoking history and a 28- year history of coal mine dust exposure. He concluded that the mild obstructive defect and mild bronchitis were caused primarily by coal mine dust exposure and would represent legal pneumoconiosis. Dr. Baker stated that there was no way to exactly partition the effects of coal dust exposure and cigarette smoking on any respiratory impairment but noted that studies have suggested that ½ to one year of coal mine dust exposure was roughly equal to one year of cigarette smoking. He added that since coal mine dust exposure greatly exceeded cigarette smoking in this case, he felt that the primary cause of the obstructive airway disease and mild bronchitis was coal dust exposure. Dr. Baker stated that Claimant had a class 2 or 10-25% impairment of the whole person which was a non-disabling impairment for doing Claimant's usual coal mine work. In other words, Claimant maintained the ability to work in the coal mines and was not impaired from his coal mine employment.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
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> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal

workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2005). In this case, the Claimant's medical records indicate that he has been diagnosed with pneumoconiosis, as well as chronic obstructive pulmonary disease, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

The available x-ray in this case has been read by one reviewer to be positive for pneumoconiosis, and another reviewer to be negative. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2005); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). In this case, Dr. Baker, who read the x-ray as positive, is a B-reader. Dr. Wiot, who read the x-ray as negative, is dually qualified, as he is a board-certified radiologist, as well as a B-reader. Giving greater weight to the reading by the dually qualified reader, I find this x-ray to be negaitive for pneumoconiosis. Therefore, the Claimant cannot be found to have pneumoconiosis on the basis of the x-ray evidence.

I must next consider the medical opinions offered by Dr. Baker. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc).

Dr. Baker diagnosed Claimant as having clinical pneumoconiosis, based on a positive chest x-ray and history of coal mine dust exposure, and legal pneumoconiosis, based on a mild obstructive impairment revealed by pulmonary function studies, caused by coal dust exposure and cigarette smoking, with a much longer history of exposure to coal dust than to cigarette smoke.

First, I find that the evidence in this matter does not support Dr. Baker's finding of clinical pneumoconiosis. He based his diagnosis on a positive chest x-ray and history of coal dust exposure. As noted above, I found that the more credible x-ray interpretation was negative for pneumoconiosis. Therefore, I find that Dr. Baker's opinion regarding the presence of clinical pneumoconiosis is not well-reasoned and is not consistent with the objective diagnostic testing.

Conversely, I accord great weight to Dr. Baker's diagnosis of legal pneumoconiosis. His conclusion was well-reasoned and well-documented and consistent with Claimant's short, remote smoking history, occupational history of 27 years of coal mine dust exposure, objective diagnostic testing documenting the presence of a mild obstructive impairment, physical examination, and subjective complaints.

There is no contrary evidence of record.

Based on the foregoing discussion, I find Claimant has established the existence of pneumoconiosis pursuant to §718.202(a)(4).

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2005). The Claimant was employed as a miner for at least 27 years, and therefore is entitled to the presumption. The Employer has not submitted any evidence to rebut said presumption. Accordingly, I find that Claimant has established that his pneumoconiosis was caused by his coal mine employment pursuant to §718.203(a).

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2005), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2005). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2005). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2005); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider the pulmonary function studies, blood gas study and medical opinions.

Neither the pulmonary function studies, nor the blood gas study, demonstrated total disability. Dr. Baker, the only physician who rendered an opinion in this matter, opined Claimant had a Class 2 impairment but nonetheless retained the capacity to perform his last coal mine employment.

I accord great weight to the highly qualified opinion of Dr. Baker on this issue. I find his opinion to be well-reasoned and well-documented, and consistent with the objective diagnostic testing that showed the presence of only a mild obstructive impairment, arterial blood gases that were within normal limits, and the exertional requirements of Claimant's job. There is no contrary evidence in the record. Thus I find Claimant has failed to establish total disability within the meaning of §718.204(b)(2)(iv).

In weighing all of the evidence on the issue of total disability, I find Claimant has failed to establish the existence of a totally disabling pulmonary or respiratory impairment.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that he is totally disabled due to a pulmonary or respiratory impairment, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Tommy Ray Hite on March 19, 2003, is hereby DENIED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).